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Report on the

Intercountry meeting on health and devlopment in slum areas using the CBI approach and urban health equity assessment and response tool

Cairo, Egypt
27–29 September 2010

World Health Organization
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Executive summary

An intercountry meeting was held in Cairo, Egypt, from 27 to 29 September 2010 to share the experience of the Tehran Municipality, Islamic Republic of Iran, in the implementation of the World Health Organization (WHO) Urban Health Equity Assessment and Response Tool (HEART) with representatives from five cities in Egypt, Morocco, Pakistan, Sudan and Tunisia.

The countries of the WHO Eastern Mediterranean Region have been experiencing rapid urbanization for the past three decades, due to an increase in migration from rural to urban areas as well as high urban indigenous growth. Urbanization is associated with serious health challenges related to the social determinants of health, environment, violence, road safety and unhealthy lifestyles globally.

During the workshop the participants practised implementing the different stages of Urban HEART through various working groups, discussions and exercises. The participants were assisted in the development a plan of action to introduce Urban HEART in the model cities. The meeting was attended by representatives of municipalities, health departments from model districts, as well as national and WHO community-based initiative focal points from Egypt, Morocco, Pakistan, Sudan and Tunisia.

It was concluded that Urban HEART is a decision-making tool that facilitates urban health equity assessment and response. High-level political commitment, formation of a multisectoral team, active participation of representatives of different development sectors and the selection of valid data using available sources are all factors that will lead to the success of the programme. WHO will provide technical support to the five selected cities that will act as regional models and will follow-up the programme's progress.

1. Introduction

The countries of the World Health Organization (WHO) Eastern Mediterranean Region have been going through rapid urbanization for the past three decades, due to an increase in migration from rural to urban areas as well as high urban indigenous growth. Urbanization is associated with serious health challenges related to the social determinants of health, environment, violence, road safety and unhealthy lifestyles globally. The most frequent fundamental challenges interlinked with urban health encompass air pollution, poor living conditions such as no or poor sanitary and waste facilities, inaccessibility of health and recreation facilities, poor infrastructure, lack of medical professionals and medicine, high rates of noncommunicable diseases, child malnutrition, poor transport and communication facilities, poverty, child labour, crime and illiteracy.

Regardless of the evidence, only a few countries have examined their inter- or intra-city health inequities, and not many do so regularly. Information that shows the gaps between cities or within the same city is a crucial requirement to prompt appropriate local actions to promote health equity. Evidence should be comprehensive enough to provide hints on key health determinants and concise enough to facilitate policy-making and prioritization of interventions.

In order to facilitate the process of proactively addressing health inequities, WHO collaborated with 17 cities from 10 countries[1] in 2008–09 to pilot-test and develop a tool called the Urban Health Equity Assessment and Response Tool (Urban HEART). Urban HEART was implemented in Tehran, Islamic Republic of Iran, as a model city from the Eastern Mediterranean Region.

[1] The 10 countries are Brazil, Indonesia, Islamic Republic of Iran, Kenya, Malaysia, Mexico, Mongolia, Philippines, Sri Lanka and Viet Nam.

The introduction of Urban HEART guides local policy-makers and communities through a standardized procedure of gathering relevant evidence and planning efficiently for appropriate actions to tackle health inequities. This collective effort towards a common goal has galvanized both city governments and communities to recognize and take action on health inequities. It is envisaged that cities with varied contexts can locally adapt and institutionalize Urban HEART, while maintaining its core concepts and principles.

An intercountry meeting was held in Cairo, Egypt, from 27 to 29 September 2010 in order to share the experience of the Tehran Municipality in the implementation of the WHO Urban Health Equity Assessment and Response Tool (HEART) with representatives of five cities from Egypt, Morocco, Pakistan, Sudan and Tunisia. During the workshop the participants practised implementing the different stages of Urban HEART through various working groups, discussions and exercises. The participants were assisted in the development of a plan of action to introduce Urban HEART in the model cities. The meeting was organized by the World Health Organization Regional Office for the Eastern Mediterranean in collaboration with the WHO Centre for Health Development, Kobe, Japan, and was attended by representatives of the municipalities and health departments from model districts, national and WHO community-based initiative focal points and authors of WHO-commissioned case studies on urban inequity from Egypt, Morocco, Pakistan, Sudan and Tunisia.

The objectives of the meeting were to:

- orient representatives of selected countries on the importance of the problems urban slums face, health equity, the community-based initiative approach and Urban HEART as tools and strategies addressing health inequity
- share the experiences of the Tehran Municipality on Urban HEART
- develop an outline of the cities' plans to assess health equity gaps and their response to priority health challenges in selected slum areas.

Dr Mohammad Assai, Regional Adviser, Community-based Initiatives, WHO Regional Office for the Eastern Mediterranean, briefed participants on the aims of the

meeting and the outcomes that were expected from discussions, which included:

- better understanding of urban social determinants of health, risks and priorities
- identify and analyse health opportunities and health outcomes between different socioeconomic groups of the people living in different parts of the city
- improve intersectoral action for health
- encourage/ facilitate evidence based priority setting and planning
- use the Urban HEART MATRIX to monitor the progress of interventions
- mobilize the community to promote health equity.

The meeting was inaugurated by Dr Hussein Gezairy, WHO Regional Director for the Eastern Mediterranean; he acknowledged the numerous health challenges in urban areas in the Eastern Mediterranean Region and noted that they were becoming more acute and complex due to rapid urbanization, economic recession and serious shortcomings in city governance and urban planning. Dr Gezairy stressed the urgency of achieving the Millennium Development Goals (MDGs) some or all of which are relevant in urban slums. The WHO Urban Health Equity Assessment and Response Tool (Urban HEART) was a solution for bringing equity to the table and energizing the ongoing activities at city level for achieving the MDGs.

Dr Geziary commended the Urban HEART experience in the Islamic Republic of Iran, which was field-tested in the 22 districts of Tehran and would be drawn upon as an evidence-based example for other cities in the Region. The experience in Tehran showed that this tool not only identified the gaps and inequities but was a powerful instrument for promoting, energizing and involving everyone in health development in cities.

The Regional Director emphasized his firm belief that the leadership, commitment and partnership of the municipalities in urban health were steps in the right direction. Local leadership, a partnership approach and focus on equity and social justice were fully in line with the 1978 Alma-Ata declaration on primary health care. The key objectives of Urban HEART were to assist communities to identify gaps, design interventions and promote health equity. In addition, it would help policy-makers achieve a

better understanding of the social determinants of health and associated health outcomes.

Dr Gezairy pledged to support the 209 cities in the Region that had registered for the World Health Day 2010 campaign "1000 cities, 1000 lives", a global initiative to improve the health and social conditions of citizens. He acknowledged and applauded the commitment of all the mayors and governors and welcomed them to the healthy city regional network. There were similarities between the Urban HEART initiative and the healthy cities programme as they both placed the health challenges in cities at the top of the city development agenda, sought high-level political commitment, raised awareness and brought people into the mainstream of health development.

Dr Gezairy concluded by calling upon the meeting participants from five countries of the Region to work together to assess health equity, find equity gaps and promote this strategy within other cities in their countries. He stressed the need to motivate key local policy-makers to support work on the social determinants of health, to enhance community empowerment in local health and social development, to design a sustainable mechanism for intersectoral collaboration and partnership for urban health development, and finally to develop strategies to reduce urban health inequity.

Dr Jacob Kumaresan, Director, WHO Centre for Health Development, Kobe, Japan, called upon leaders from countries in the Region to share experiences and employ the tools created to address urban health issues. Urbanization was one of the greatest challenges of humanity in the 21st century; since today three billion people lived in cities, of which almost a billion people lived in slums. By 2030, six out of every 10 people would be city dwellers, rising to seven out of every 10 people by 2050. Dr Kumaresan nevertheless acknowledged that urbanization could be a positive determinant of health; but only when under appropriate circumstances where city governments and policies addressed the key determinants of health.

He then highlighted the World Health Organization's recognition of urbanization as a principal determinant of health throughout 2010 given the two key global events, World Health Day in April 2010 and the Global Forum on Healthy Urbanization in November 2010, to promote healthy

urbanization. Dr Kumaresan introduced the Urban Health Equity Assessment and Response Tool (Urban HEART) as a tool to facilitate this process enabling mayors and local authorities to plan actions that reduce inequities in health and health determinants in their cities. He wished the meeting participants success in their efforts to reduce inequities and improve the living standards of all urban residents.

The agenda, programme, list of participants and meeting evaluation results are included as Annexes 1, 2, 3 and 4, respectively.

2. Technical presentations

2.1 Reducing health inequity in urban areas through the community-based initiatives approach

Dr Abdullah Assa'edi, WHO Deputy Regional Director for the Eastern Mediterranean

Health inequity is people in certain categories (urban or rural, different races, sex, age groups, special conditions) who do not have equal access to health services for various reasons including: financial, cultural and geographical access. Five case studies were carried out by the WHO Regional Office for the Eastern Mediterranean assessing health inequity in Sale in Morocco, Cairo in Egypt, Ariana in Tunisia, Rawalpindi in Pakistan and Khartoum in Sudan. Urban health inequity studies provide evidence of urbanization's impact on the health status of individuals and communities, and the results of the studies will be used so that local policy-makers can prioritize health challenges associated with urbanization in their cities. The results reveal that the Eastern Mediterranean Region is like other regions facing disparities between rural and urban, urban slums and other parts of the cities.

The urban health equity assessment and response tool piloted in Tehran, Islamic Republic of Iran, will enable the assessment of existing health and social situations. This can be achieved through finding key indicators and creating plans to fill the priority gaps through community ownership and intersectoral action for health development. Therefore, it is expected that through the Urban HEART model cities can promote community ownership in overall development; structure intersectoral action for health at the city level; build partnerships and generate resources for improving health and social conditions in slum areas and learn how to address health equity and social determinants of health. In addition use of information for urban health planning and action has to be enhanced. It is important to highlight that political commitment, the plan for expansion of Urban HEART and strengthening networking and the exchange of experiences are another critical points that have to be well considered in the cities' Urban HEART action plan.

WHO will continue to support Member States to:

- introduce Urban HEART using the experience of Tehran as a guide
- identify major gaps and apply appropriate local solutions lead by the community and supported by the development sectors
- document Urban HEART implementation, use it for policy-making, advocacy and expansion
- participate in presenting the findings to the policy-makers.

Urban HEART and community-based initiatives should be linked to reduce urban health inequity. The reason is that universal coverage reform creates greater equity demand by ensuring political commitment. Nevertheless political commitment is required with focus on two major accelerating actions for health equity, both of which are suggested by WHO:

- visibility of health inequity requires evidence-building through Urban HEART
- civil society participation addressing organized social demands; in the Eastern Mediterranean Region community-based initiatives are used as the tool to enhance civil society participation and ownership.

Therefore, the implementation of Urban HEART using the community-based initiatives approach in the Region can facilitate simplified useful results in this global movement.

2.2 Overview of Tehran's experience with Urban HEART

Dr Mohsen Asadi Lari, Iran University of Medical Sciences and Health Services

Dr Lari provided an overview about how Urban HEART was introduced, organized and implemented under the leadership of the Tehran Municipality. His presentation included the following: the establishment of the organizing team; the selection and finalization of the indicators and the required tools, conducting surveys for the information that was not available in the 22 districts of Tehran; analysing the data, detecting the gaps; setting priorities in neighbourhoods', evidence-based policy-making and finally community-based participatory interventions to reduce the gaps.

Some of the highlights of his presentation are as follows:

- establishment of four working groups, one for each domain
- each indicator is given a responsible organization
- active involvement of all stakeholders from the starting point until the end.
- formation of a technical advisory committee to finalize and approve the indicators
- implementation of a pilot survey to test the feasibility of the tools and indicators. For the pilot test 250 questionnaires (one per household) were filled in in two days
- formation of a steering committee chaired by the deputy mayor of Tehran facilitated coordination with the relevant organizations such as police, official bureaus in different districts, district municipalities, investigation organisation and deciding upon all aspects of the pilot study, including the content of the questionnaire and timetables.
- Technical assistance of the Regional Office and WHO Centre for Health and Development, Kobe, Japan.

The stakeholders included different departments in Tehran municipality; Ministry of Health and Medical Education, MPO, education department, housing department, welfare organization, insurance organization, energy department, MPs, city council, medical universities and national experts.

Sample size calculation based on pilot findings: 960 households per district: 21 120, trained surveyors: 390, supervised at three levels: field, mentors and headquarters. The duration of the survey was 55 days followed by data entry, editing, entry re-examination, data processing, telephone calls to track missing items, etc., and re-evaluation of 10% through telephone calls and 1% random household surveys by field supervisors.

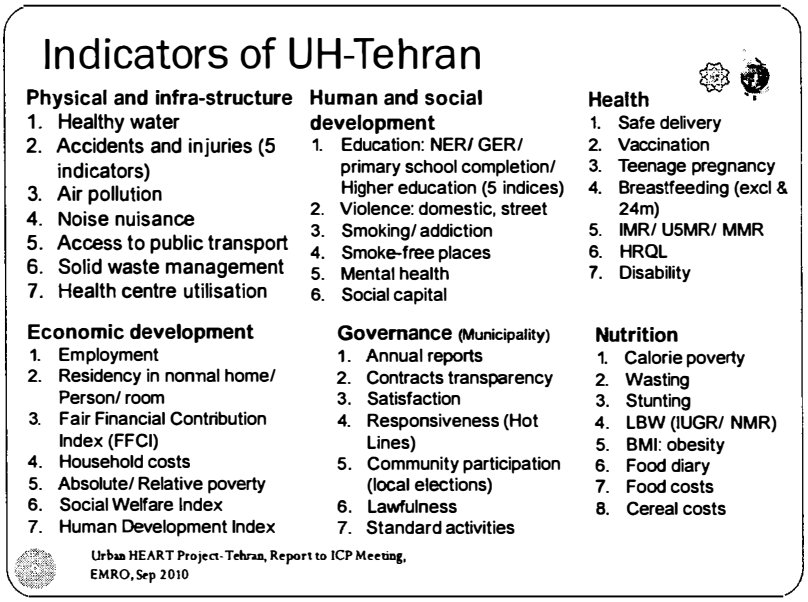
A statistics team was established after the pilot test, and working groups were advised on statistical points after the technical advisory committee reviewed all the processes of data analysis.

A framework for report was agreed in the steering committee, and a special team was assigned to document all parts of the project. The reports were made in different ways: written; graphs; matrices; and maps.

2.3 Indicators for data collection

Professor Hossain Malek Afzali, Tehran University of Medical Sciences

The following indicators were agreed by members of technical advisory committee formed in Tehran Municipality.



2.4 Outcome and results of the Tehran Urban HEART experience

Professor Hossain Malek Afzali, Tehran University of Medical Sciences

Urban HEART measures inequalities in six policy domains: physical and environmental infrastructure, social and human development, economic development, governance, health and nutrition, with 42 indicators altogether. Overall the results demonstrated clear discrepancies in equity for those residing in the more impoverished districts of Tehran, particularly districts 15–19; whereas in the more affluent districts, principally 1–6, the standards of living were generally higher. The results in the six domains included the following.

Physical and infrastructure domain

Persons per room

The persons per room figure is evenly distributed in Tehran; affluent districts (1, 2, 3, 5 and 6) tend to accommodate fewer people than disadvantaged areas (districts 15–19).

Tobacco consumption

4394 children under 5 years (5.4% of total population surveyed) were identified in this study; among them 1089 (24.8%) children living in a family with a smoker. Prevalence of children under 5 years with environmental tobacco smoke varied significantly within 22 districts, between 15.8% (district 2) and 35.8% (district 16) located in more disadvantaged areas.

Piped water

Most of districts had 100% independent access to tap water, and the maximum difference was seen in just 1.5%, i.e. fewer than 15 households in district 17 had shared access to tap water. Lack of access to tap water, however, could be seen more in deprived districts of Tehran. The quality of water was unevenly distributed, too.

Transport

Car ownership was three times higher in affluent districts than in disadvantaged quarters. Residents in some districts (districts 13, 14, 17 and 18) spent more time in reaching or boarding public transport than people in other districts.

Social and human development domain

Literacy

Disadvantaged districts have up to seven times more illiteracy than affluent districts, and females experience double the rate of illiteracy compared with men.

Higher education

Inhabitants of those more disadvantaged districts, particularly districts 15–20, tended to have a lower higher education attendance. 18.5% of household heads stated they had a university degree (or were studying at university); of these 5.7% were technicians (attending a two-year course at university), 10.4% had a bachelors degree, and 2.4% had a masters or higher degree.

Violence

Domestic violence was defined in three categories: verbal, physical without complications, and physical violence with complications. From the 22 135 families interviewed, 6.7% had a positive response to this question, indicating that they had experienced some category of violence. Overall physical violence was equally dispersed across all districts irrespective of equity; district 12 followed by district 7 had the highest violence rates, both of which are mid-income districts.

Health domain

Birth rate

Disadvantaged districts (districts 17–19) had up to four times the birth rate of the more affluent counterparts.

Mental health

Women had a relative risk of mental disorders of 1.3 compared with men. The risk of mental disorders increased with age. Divorced or widowed people were 1.5 times more at risk. The highest risk of mental disorders was seen in housewives and unemployed men.

Elderly population

Elderly population was mainly in affluent districts, with the highest rate in district 6 (11.1%). Districts 18–19 (marginal zones in south-west) and 21–22 (as the newest districts) have the least rates of elderly.

Vaccination

Vaccination coverage of children above 13 months old is unevenly distributed within Tehran's districts and is surprisingly not correlated with equity; prompt action is needed in this regard.

Economic domain

Health costs

Health costs consisted of a household's average outpatient (medical visits), inpatient (hospitalization), medicine costs,

transport to medical centres, diagnostic, rehabilitation and other relevant health costs. The results indicated that affluent areas (districts 1, 3 and 6) had much higher health costs.

Employment status

According to the official definition by the Statistical Centre of Iran, over-10-year-old employment is calculated for this indicator. However the Urban HEART team calculated over-15-year-old unemployment rate, which had a similar uneven distribution to that of the over-10-year-old employment rate across districts of Tehran with no apparent parallel to equity (districts 12–15, mid equity areas, appeared to be the worst affected).

Female-headed households

Distribution of the female-headed households was consistently higher in some districts.

Nutrition domain

Calorie intake

While all households (out of the 2300 households interviewed within the 22 districts of Tehran) had an average calorie intake more than 2100 kcal per person per day, people in advantaged zones (districts 1–3) had a mean calorie intake less than more deprived areas (districts 17–19).

Body mass index (BMI)

A BMI between 25 and 30 is considered as overweight and more than 30 as obese. The results showed that a BMI of 25 and above, in other words those individuals who are overweight and obese in Tehran, was steadily distributed across all districts with no specific correlation to equity with the exception of district 1, a privileged zone, which suffered the least obesity.

Mean consumption of meat intake

Mean consumption of seven food groups were calculated: cereals, fruits, vegetables, dairy, meat, oil, beverages and carbohydrates. The results indicate that the food groups which provide calories (bread and cereals, oil and carbohydrates) were more likely to be used in disadvantaged

districts; while in more affluent districts meat and vegetable consumption were more prevalent.

Governance domain

In this domain, eight indicators were developed to measure the transparency; satisfaction and responsiveness were merely measured in the main Urban HEART survey.

Households familiar with the main municipality hot-line

Less privileged districts were not as familiar with the main municipality hot-line as those households in the more privileged districts.

Households satisfied with the municipality hot-line

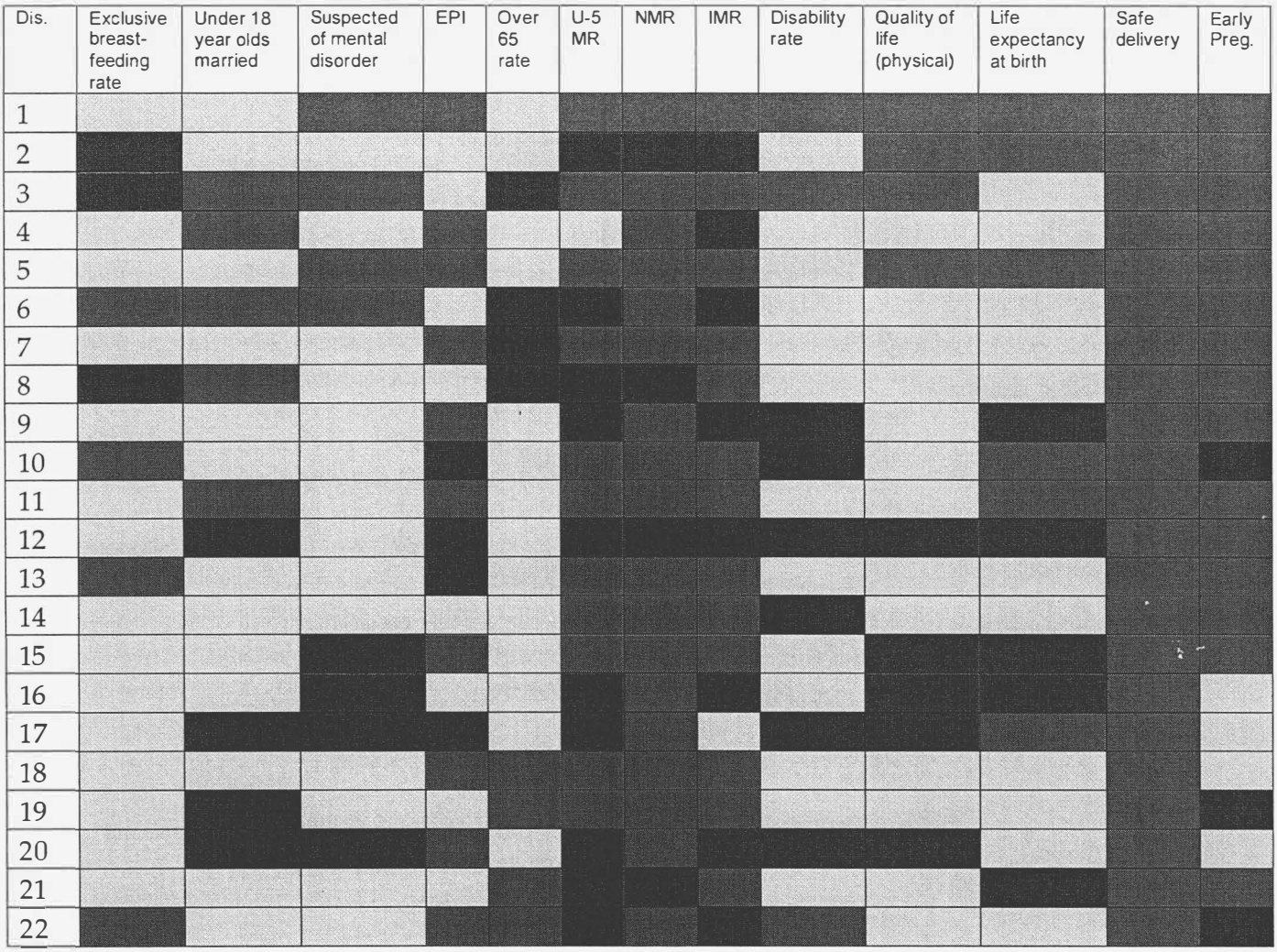
Satisfaction with the municipality hot-line was distributed to a certain extent proportionally across districts; though interestingly district 3, one of the more affluent areas, and district 22, one of the more impoverished quarters, proved equally to be the most satisfied.

Households satisfied with Tehran Municipality

The general level of satisfaction with Tehran Municipality was consistently distributed across all districts.

Using the Matrix tool

For each domain a matrix was developed. Below is the HEART matrix related to the health domain, showing the health status in 22 districts of Tehran:



At or above national target level

Above national average but below national target level

Below national average

2.5 Response plan, lessons learnt, challenges and replication

Professor Hossain Malek Afzali, Tehran University of Medical Sciences

Selection of the Urban HEART indicators is a scientific, democratic and political process, and thus it is necessary to identify which indicators are more responsive to equity. The three key messages learnt from Tehran's experience are: building a system to respond to gaps; strengthening intersectoral collaboration; and involving the community in assessment and intervention. The assessment took place in six different domains, and some of the findings related to

each domain are in this report (see above). The full report of Tehran Urban HEART was shared by CD with all participants of the meeting.

The following important suggestions were made.

- A clear and detailed plan of action should be created which will function as a fundamental roadmap for the future. Working closely with the municipality is crucial; Tehran was able to succeed due to the high level of commitment by the mayor of Tehran.

- Familiarity with the local context and adaption of Urban HEART according to local needs is vital. For instance in more religious or conservative districts of Tehran different application measures were applied and religious leaders direction and consent was sought.

- Spending should be according to capacity and priorities; thus an overall assessment of the area should be undertaken in order not to waste resources.

- Expansion of Urban HEART is essential; take on an advocacy role for the entire country. This includes assessing progress; the Tehran Municipality is constantly asked by all provinces about its progress in relation to Urban HEART, hence good documentation and planning are imperative.

- The use of all available data sources and data gathering when secondary data are not available are essential elements of Urban HEART; for which it is essential to empower the community to be partners in data gathering. Data collection and analysis should be dealt with by the appropriate individuals from the relevant sectors.

- A short-term plan and the selection of a small pilot area in a city to demonstrate Urban HEART's impact is important to encourage the community and government to follow suit. Thus an initial small intervention project is a key promotional strategy.

- Learn from others' experiences and establish strategies to simply the implementation and analysis process. For instance divide cities into districts following Tehran's successful model (notably Tehran divided the city into

22 districts) to demonstrate the full impact of Urban HEART and employ the Matrix tool to draw clear comparisons of health indicators in different areas of the city.

The three main problems that were identified in the Tehran experience were the size of the project, the lack of readily available data and the low level of community participation. Nevertheless as demonstrated by the evidence of the matrices displaying health indicators in 22 districts of Tehran Urban HEART has proved to be a great success. Above all Urban HEART requires those involved to be action orientated and good communicators; following Tehran's model will enable a replicable outcome as this has been proven to be the case in many districts.

2.6 Module 1: building an inclusive team

Dr Amit Prasad, WHO Centre for Health Development, Kobe, Japan

Building partnerships with various stakeholders is crucial to the Urban HEART process. In addition, creating an inclusive team may be time-consuming, but will be one of the most important steps for the productive implementation of Urban HEART.

The participants were asked to map available resources or sources of funds and identify objectives and strategies for the introduction of Urban HEART in their respective cities. By the end of the session, participants were informed about the importance of building partnerships and sharing data with various stakeholders for Urban HEART and were thus positioned to continue this practice in reality once they go back to their pilot districts for Urban HEART.

Summary outcomes of the session are available in the working group part of this report.

2.7 Assessment: modules 2, 3, 4
Define local indicator set and benchmarks (2), assemble relevant valid data (3), generate evidence (4)

Dr Amit Prasad, WHO Centre for Health Development, Kobe, Japan

The session started with a presentation on assessment modules, including instructions for group work, followed by group work where participants were asked to identify local indicators and data sources for the target cities. There are 12 Urban HEART core indicators that every city must try to

adopt when implementing the tool. These are shown below in the following table.

Health outcomes	*Physical environment and infrastructure*	*Social and human development*	*Economics*	*Governance*
Infant mortality	Access to safe water	Completion of primary education	Unemployment	Government spending on health
Diabetes	Access to improved sanitation	Skilled birth attendance		
Tuberculosis		Fully immunized children		
Road traffic injuries		Prevalence of tobacco smoking		

The core indicators are recommended for three reasons: First, they have been shown to be globally relevant to urban health, especially in relation to equity; second, they are usually available from routinely collected data; and finally, they are readily comparable across cities and countries.

In addition to the core indicators, Urban HEART also includes a menu of additional indicators. The purpose of these indicators is to equip teams with options for adapting their Urban HEART indicator set to the unique conditions of their city.

The objective of this session was to review how health, social and economic indicators can reveal health inequities and also to convey the necessity of adopting all 12 Urban HEART core indicators and using the existing, available datasets for the target cities. The session should have improved participants understanding of how indicators can reveal health inequities and also the importance of carefully selecting indicators and benchmarks; in addition to recognizing the best valid sources for the Urban HEART data. The session discussed the process necessary to assemble relevant and valid data. In addition participants were asked to evaluate their indicator set based on the following criteria: relevance; inclusiveness; feasibility; comparability with other sites or targets; comparability over time; and efficiency.

Module 4 was generating evidence, which explained how to create the Matrix and the Monitor. It was demonstrated the way in which the Matrix and the Monitor can reveal the types of health equity problems that are the most and least pronounced in a city whilst identifying who is the most and least affected. By the end of the session, participants were able to analyse the Matrix and the Monitor and understand what the charts/graphs reveal about health inequities within or between cities/regions.

A practical exercise accompanied the session to produce the Matrix and the Monitor through asking participants to gather around an incomplete wall display of the Matrix and the Monitor.

The facilitator briefly described the data in the Matrix and asked volunteers to fill in the appropriate colour (red, yellow or green) one box at a time based on the information provided in the chart. The group assisted the volunteer to ensure the box was coloured with the correct colour.

The participants were asked to turn their attention to the Monitor graph whilst the data for the Monitor were explained. Volunteers were then requested to fill in the appropriate colour (red, yellow or green) and shape (diamond, circle or square) around the points marked with an *x* on the graph based on the data provided. Although this activity may seem simple, it nevertheless helped participants gain confidence in generating and understanding the data displayed. The session was complimented by active involvement of the participants.

2.8 Response: modules 5 and 6
Prioritize health equity issues (5), identify best response (6)

Dr Amit Prasad, WHO Centre for Health Development, Kobe, Japan

Health equity gaps and gradients must be identified and prioritized in order to concentrate on the problems which require action in the pilot/model cities. Participants were instructed how to use the data generated by the Matrix and the Monitor in order to assess health inequities and prioritize problems requiring action at the city level.

Different scenarios were employed to illustrate priority health equity issues. In scenario 1 the stakeholders had identified tobacco control as a major priority. The Matrix showed that the prevalence of tobacco smoking was higher than the national average in three out of the six neighbourhoods (in red). Other neighbourhoods had achieved the desired target level (in green). Based on these results, stakeholders decided to investigate tobacco use in the vulnerable neighbourhoods in more depth (and to look for possible lessons from the healthier neighbourhoods). They prioritized response strategies to promote smoking cessation in the vulnerable neighbourhoods.

In scenario 2 the stakeholders were particularly interested in child mortality trends. The Monitor showed the under-five mortality in City A (represented by squares) was considerably higher than the regional average (circles) and the best-performing cities in the region (diamonds). Moreover, the mortality rate was improving more slowly than in other cities in the region. Stakeholders decided to change the approach to children's health services in City A.

The participants were given 30 minutes to answer the following questions.

- Is there a general consensus among the stakeholders for the priority areas identified?

- How would you propose resolving conflicts between stakeholders?

- Are there any immediate concerns in the city which should be addressed first?

After the groups reached a consensus on the questions, the facilitator asked the working groups to identify two or three priority areas for which intervention plans should be developed. The groups were asked also to provide brief explanations for their choices.

Once the working groups identified the priority health equity issues, the next step was to select the appropriate response. This was discussed during five working group sessions in which the participants selected appropriate interventions that addressed the priority health inequities chosen earlier.

The participants reviewed the Matrix and the Monitor graphs developed earlier and were asked to select the best interventions aligned with the following criteria:

- reduce health inequities
- available local resources
- acceptable by affected communities and other key players
- achievable within specific timeframe
- likely to be effective and efficient
- complies with the national priorities.

The participants were asked to produce clear recommendations for governments and communities to reduce the priority health inequities uncovered through Urban HEART.

2.9 Outline of a country plan of action to introduce Urban HEART

Dr Mohammad Assai, Regional Adviser, Community-based Initiatives, WHO Regional Office for the Eastern Mediterranean

A brief introduction was provided on this session in which each group of participants was asked to pinpoint the most important activities needed in the assessment part and to identify the following for each activity:

- resources
- stakeholders/partners
- outputs/outcomes
- timeline needed to successfully carry out the activity.

The same exercise was performed for the response part. Finally the groups were asked to select one activity from the assessment and one from the response part and for each activity identify:

- resources
- stakeholders/partners
- outputs/outcomes
- timeline needed to successfully carry out the activity.

The session ensured that participants were better prepared to introduce Urban HEART once they returned to their home cities. Listed below are three of the plans of action.

Urban HEART plan of action for Giza, Egypt

1. Political commitment	
Resources	Documents, materials, briefing memo
Stakeholders/partners	Giza Governor.
Outcomes/outcomes	Meeting minutes
Timeline	End of October 2010
2. Team building	
Resources	Documents, materials, access to relevant stakeholders
Stakeholders/partners	Health, social solidarity, NGOs, environment, all government sectors and other relevant partners.
Outcomes/outcomes	Team formation of different sectors
Timeline	Mid November 2010
3. Orientation workshop	
Resources	Urban Heart workshop team, documents, venue, budget, presenters
Stakeholders/partners	Health, social solidarity, NGOs, environment, all government sectors and other relevant partners
Outcomes/outcomes	Documents for workshop, team action plan, data sharing to be submitted by all collaborators
Timeline	Mid December 2010
4. Data collection and field survey	
Resources	Phone calls, fax, developing the tool, budget, training surveyors, available data
Stakeholders/partners	All sectors
Outcomes/outcomes	Data collected, analysed and verified
Timeline	December 2010–February 2011
5. Identifying interventions and action plan	
Resources	Data collected, Urban HEART tool
Stakeholders/partners	All team members and stakeholders to identify priority equity gaps
Outcomes/outcomes	Plan of action developed according to the Urban Heart tool by the team; it should be evidence-based responding to health inequities in the selected area of the Giza governorate
Timeline	March–December 2011

Urban HEART plan of action for Sale, Morocco

Activity	*Responsible person*	*Time frame*	*Resources*	*Monitoring indicators*
Development of a preliminary report	National Urban HEART Team	December 2010	Development of specific database for each sector	Availability of updated data on social sectors
Identify meaningful core indicators and complete the rest of the data through surveys	National Urban HEART Team	December 2010–January 2011	Educational tool and logistics	Final core indicators, completed questionnaires and processed data
Preparation of the final report of the study	Educational tools and logistics	March 2011	National Urban HEART team	Development of matrices and identify the list of priorities
Development of action plan following priority setting	Steering committee chaired by the Governor of Sale	April 2011	Educational tool and logistics	Action plan approved by different sectors
Capacity building and briefing of high level managers and policy makers	National Urban HEART team	4–8 October 2011	Availability of representative of Sale Municipality/Ministry of Interior, Ministry of Health and other sectors using the report and recommendations from the regional meeting held in Cairo, September 2010	Report of the briefing meeting and degree of interaction and acceptance of project
Arranging a working group meeting with the Governor	Focal point in the prefecture of Sale	10 October 2011	Presentations using Urban HEART tool	Adoption of the project and identification of its territorial areas
Arranging a meeting with local stakeholders, Ministry of Health, urban community, community elected representatives and interested civil society	City organizing committee	25 October 2011	Presentations by the city organizing committee	Harmonization of the vision and method of implementation
Social preparation for the start of the project	City organizing committee	18 November 2011	Develop presentation and briefing materials by the organizing committee	Urban HEART project started in Sale

Urban HEART Plan of Acton for Rawalpindi, Pakistan

Activity	*Responsible person*	*Time-frame*	*Resources*	*Monitoring indicators*
Developing an inclusive district urban HEART team	EDO(Health) Rawalpindi District along with Focal person of the Urban HEART Project	December 2010	Financial resources	Urban HEART team for Rawalpindi, Pakistan developed
1.Identify core indicators 2.Analyse the available data to do gap analysis 3.Conduct surveys to fill the gaps	1. Focal person of Urban HEART team 2. Researchers	30 March, 2011	1.Financial resources 2.Experts in epidemiology 3. Field researchers 4. Volunteers 5. Computers, printers, multimedia, broadband internet connections, stationery	1. Core indicators developed 2. Gaps in current data identified 3. Gaps filled through surveys
Develop urban HEART equity matrix and urban HEART equity monitor	Urban HEART team and researchers	15 April 2011	Expert, software	Urban HEART Matrix and Monitor developed
Orientation and capacity-building of high level managers and policy-makers	Urban HEART team and researchers	30 April 2011	Financial resources, educational tool and logistics	High level management ready to support urban HEART project
Identifying priorities and response strategies	Urban HEART team and all the line departments	15 May 2011	Financial resources, educational tool and logistics	Priorities identified and set
Selecting relevant interventions	UH team and all the line departments	30 May 2011	Financial resources, educational tool and logistics	Interventions selected
Developing a plan of action for response	Urban HEART team	30 August 2011	Financial resources, experts and logistics	Plan of action developed
Approval of plan of action from policy makers and high level management	Urban HEART team	30 September 2011	Presentations using urban HEART tool	Approval and adoption of the plan of action
Arranging meetings with local stakeholders, Ministry of Health, other ministries, urban community, elected representatives, civil society and development partners	Urban HEART team	30 October 2011	Financial resources for different meetings	Partners ready to support the plan of action

3. Group work

Group work 1

Stakeholder analysis: the five working groups were asked the following fundamental questions.

Who should be on the proposed Urban HEART team for your city?

What are the steps to get the stakeholders involved?

What are the resources needed to begin building a team in your city?

The working groups were asked to: discuss and create a list of local and national stakeholders; identify their roles and responsibilities; ascertain the possible difficulties they may face in engaging them in Urban HEART; and define the degree of importance of their inclusion and involvement in the Urban HEART team.

The working groups came out with a list of key stakeholders/sectors prevalent in all five countries: municipalities, health, education, nongovernmental organizations, community leaders, information, communication and media, volunteers and social welfare organizations. Working groups confirmed that there was no real difficulty in approaching and engaging stakeholders/sectors in the Urban HEART process. Although the importance of including the above mentioned stakeholders/sectors in Urban HEART cannot be underestimated.

Group work 2

Identify local indicator set and data sources (by each country team)

The core indicators identified by the five working groups were more or less the same. In addition benchmarks, targets and the data sources were tabulated for each core indicator. Another task required the participants to identify challenges

and problems that might arise from the set indicators in terms of selection, source, quality and resources that are available to collect the data.

Group work 3

Construct a mock Matrix and Monitor

This was done in a panel discussion in which all the participants were given some indicators from three districts as an example and were asked to colour the matrix (red, yellow or green) by comparing the average of the indicators for the districts and national level averages.

Group work 4

Identify best response (based on assessment results)

This working group assisted the participants in using the Matrix and the Monitor to prioritize their urban health and social problems. In addition it demonstrated the importance of using the support and backing of relevant sectors, communities and champions when identifying priority areas requiring intervention. The working group also assisted each group's participants to select the appropriate procedures that addressed the priority health inequities selected.

The participants of each working group were asked to answer the following questions bearing in mind the Matrix distributed to their working groups.

Is there general consensus among the stakeholders (i.e. group members) for the priority areas identified?

How would you propose resolving conflicts between stakeholders?

Are there any immediate concerns in the city which should be addressed first?

Upon reaching a general consensus within their groups the participants were asked to identify two or three priority areas or to highlight the intervention plans that should be developed.

The priority areas were listed, and a brief explanation was provided for the groups' choices. One of the participants of

each working group was asked to play the role of a mayor. The negotiation between the working groups and the mayor was assessed by all the participants through the creation of a table showing the strengths and the weaknesses of the negotiation. The participants were reminded to follow the fundamental principles of negotiation and communication and to try to employ a win–win approach in negotiation with stakeholders. Above all they were advised to be well prepared before negotiating with high-level policy-makers on urban health matters.

Group work 5

Draft an outline for a country plan of action to introduce Urban HEART and select one assessment and one response activity to be elaborated in detail in order to introduce Urban HEART in each selected city

Participants had to produce an outline for a plan of action showing the step-by-step activities that must be undertaken at city level. This was discussed in the working groups, and each group proposed some key activities bearing in mind their needs and requirements. This was followed by detailed planning for one sample assessment activity and one sample response activity through the completion of a table showing: resources, stakeholders, outcomes and the time frame.

4. Conclusions and recommendations

4.1 Conclusions

Urban HEART is a decision making tool that facilitates Urban Health Equity Assessment and Response. The tool was applied in many parts of the world including I.R of Iran from Eastern Mediterranean Region as a model country. High level political commitment, formation of a multisectoral team, active participation of representatives of different development sectors and the selection of valid data using available sources are all factors that will lead to the success of the programme. The WHO Regional Office for the Eastern Mediterranean and WHO Centre for Health Development, Kobe (Japan) will provide technical support to five selected cities that will act as regional models. WHO will follow-up the programme's progress in the five cities; this should be reported regularly by the country team. Urban HEART documentation, evidence building and expansion at the regional and national level will facilitate rising political commitment towards reducing health inequity and improving the access of disadvantaged groups to social and health services.

4.2 Recommendations

To Member States

1. Build high-level political support, commitment and advocacy for introducing Urban HEART in the model districts. This can be done through agreement on building a multisectoral team under the mayor's leadership to design and prepare a detailed plan of action for the model districts.

2. Organize briefing session/s for potential national and local partners/stakeholders, identify their roles and responsibilities and involve them in the planning and implementation process.

3. Nominate a focal point at ministry of health or municipality level to coordinate all activities and

different steps alongside WHO and other national and international stakeholders.

4. Define model districts' localities with clear boundaries to enable comparison of core indicators.

5. Design a simple, feasible, cost-effective Urban HEART plan of action that is based on local socioeconomic needs and priorities.

6. Select core health equity indicators considering local needs and priorities and use valid sources of available information. New data should be collected only to fill critical gaps in information related to the core indicators.

7. Generate evidence by creating a Matrix and a Monitor as discussed during the present meeting.

8. Prioritize health gaps using the data available at the city level.

9. Build sustained intersectoral collaboration at the city and national levels through designating the responsibility of each indicator (from assessment to response and evaluation) to the relevant development sectors.

10. Involve the community in the: needs assessment, prioritization, planning, implementation, monitoring and evaluation at the local level using the community-based initiatives approach, for example training and using the services of women health volunteers, creating women and youth groups and involving local nongovernmental organizations.

11. Build/strengthen health and other current social systems as a basic response component of Urban HEART.

To WHO

12. Provide technical support in the implementation of Urban HEART at the city level.

13. Facilitate the exchange of experiences and networking between model cities.

14. Follow-up the implementation of Urban HEART and report the progress of the programme in the five model cities.

15. Assist Member States to document and evaluate Urban Heart.

Dr Naeema Al Gasseer, WHO Assistant Regional Director for the Eastern Mediterranean, concluded the meeting with some suggestions for countries to further advocate and promote Urban HEART.

- Invest more money in research in order to generate evidence to ensure a successful intervention. Set aside 2% of the national health budget for health research.

- Use statistical indicators to their full potential and ensure good financial budgeting; this will simplify decision-makers' work.

- Streamline health and development through community involvement. The community is the principal tool to make a real impact on the ground, thus innovative methods should be employed so as to use all people and resources. For example, start with university students as young people are the doorway to the next generation and have the energy, capacity and numbers to make a real difference.

- Implement existing laws that will assist and have a direct impact on urban health; for example Egypt has a very good law on health infrastructure which should be enforced.

- Work towards achieving the MDGs; the combined work and efforts of all partners in each domain contributes to the achievement of the MDGs.

- Exploit important events such as the upcoming International Disaster Risk Reduction day on 13 October 2010 to further advocate and promote urban health. Thus internal collaboration among WHO units and intersectoral collaboration is crucial to promote and put urban health on the top of decisions-makers' agenda.

Annex 1

Agenda

1. Introduction and methodology of work

2. Reduce health inequity at urban areas through community-based initiatives approach

3. Introduction to Urban HEART

4. Share Tehran's experiences on Urban HEART

Implementation steps for using Urban HEART

5. Module 1: building an inclusive team

6. Assessment: modules 2, 3, 4
   Define local indicator set and benchmarks (2), assemble relevant valid data (3), generate evidence (4)

7. Response: modules 5 and 6
   Prioritize health equity issues (5), Identify best response (6)

8. Outline plan of action to tackle health equity at the city level

Annex 2

Programme

Monday, 27 September 2010

09:00–09:30	Opening remarks	Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean Dr Amit Prasad (on behalf of Dr Jacob Kumaresan, Director, WHO Centre for Health and Development, Kobe, Japan)
09:30–09:50	Reduce health inequity at urban areas through the community-based initiatives approach	Dr Abdullah Assa'edi, WHO Deputy Regional Director for the Eastern Mediterranean
09:50–10:00	Objectives, methodology of work and expected outcomes	Dr. Mohammad Assai, Regional Adviser, Community-based Initiatives, WHO Regional Office for the Eastern Mediterranean
10:00–10:30	Election of officers Introduction of participants Adoption of the programme	
11:15–11:45	Introduction of Urban HEART	Dr Amit Prasad
11:45–12:20	Overview of Tehran's experience on Urban HEART (step by step from assessment to response): - structural set-up and ownership (how was it planned and who was involved?) - coordination mechanism: intersectoral collaboration and community participation - data processing and analysis	Dr Mohsen Asadi, Iran University of Medical Sciences and Health Services

12:20–13:00	Questions and answers	
14:00–15:00	Continuation of Tehran Urban HEART (step by step from assessment to response): - outcomes and results of Urban HEART experience - Indicators, methodology and tools for data collection	Professor Hossain Malek Afzali, Tehran University of Medical Sciences
15:00–15:30	Questions and answers	
16:00–17:00	Continuation of Tehran Urban HEART (step by step from assessment to response): - response plan (district 9 model) - outcomes - lessons learnt/ challenges and its replicability	Professor Hossain Malek Afzali
17:00–17:30	Questions and answers	

Tuesday, 28 September 2010

08:30–09:00	**Module 1: building an inclusive team** Presentation on module 1, including instructions for group work	Dr Amit Prasad
09:00– 10:30	**Group work 1: stakeholder analysis** Map available resources or sources of funds and identifying objectives and strategies for introduction of UH (by each country team)	
11:00–11:30	Groups presentations and discussion (each group 10 minutes)	Rapporteurs of five working groups

11:30–12:30	**Assessment: modules 2, 3,** 4 Define local indicator set and benchmarks (2), assemble relevant valid data (3), generate evidence (4) Presentation on assessment modules, including instructions for group work	Dr Amit Prasad
13:30–15:00	**Group work 2** Identify local indicator set and data sources (by each country team)	Dr Amit Prasad
15:30–16:30	Groups presentations and discussion (each group 10 minutes)	Rapporteurs of working groups
16:30–17:30	**Group work 3** Construct a mock Matrix and Monitor (based on provided data)	
17:30–18:30	Groups presentations and discussion (each group 10 minutes)	Rapporteurs of working groupss

Wednesday, 29 September 2010

08:30–09:30	**Response: modules 5 and 6** Prioritize health equity issues (5), identify best response (6) Presentation on response modules, including instructions for group work	Dr Amit Prasad
09:30–10:30	**Group work 4** Identify best response (based on assessment results)	
11:00–12:00	Groups presentations and discussion (each group 10 minutes)	Rapporteurs of working groups

13:00–13:15	Instructions on preparing Urban HEART plan of action	Dr Mohammad Assai
13:15–14:30	Working group: draft an outline of country plan of action to introduce Urban HEART (who, when, what, how)	
14:30–15:30	Groups presentations and discussion (each group 10 minutes)	Rapporteurs of working groups
16:00–16:15	Final recommendations	Rapporteurs of working groups

Annex 3

List of participants

EGYPT
Dr Soad Mohamed Abd El Megeed
National focal point, Community-based initiatives
Ministry of Health
Cairo

Dr Randa Rizk
Representative of Mayor of Giza
Giza

Dr Abd Elhaleem Elbeheery
General Directorate of Health
Giza

MOROCCO
Dr Katra-Ennada Darkaoui
Head of Outpatient Care Department and National
Coordinator of Community-Based Initiatives
Directorate of Hospitals and Outpatient Care
Ministry of Health
Rabat

Dr Mehdi Nafiaa
Representative of Health Department
Sale

Ms Khadija Zemani
Representative of Municipality
Sale

PAKISTAN
Dr Zafar Iqbal Gondal
Executive District Officer
Rawalpindi

Mr Nasir Mahmood
District Officer
Chakwal

SUDAN
Dr Sumaia Mohamed Elsayed
Professor, Ahfad University for Women and author of WHO-commissioned papers on health inequity
Khartoum

Dr Hanan Mukhtar Abdo
Director of the Community Development and Partnership
Federal Ministry of Health
Khartoum

Mr Mohammed Hassan Omer
Director of Environmental Health Directorate
Ombada locality
Khartoum

Eng Elbashir Yousif Taha
Director of Civil Planning Directorate
Ombada locality
Khartoum

TUNISIA
Mr Ridha Souilem
Mayor of Ariana
Tunis

Dr Arfa Chokri
Author of WHO-commissioned paper on health inequity
Tunis

Dr Zouhaeir Fekih
Director of Studies and Planning
Ministry of Public Health
Tunis

Dr Maha Bargaoui
Representative of Health
District of Ariana
Tunis

TEMPORARY ADVISERS

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Professor of Vital Statistics
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Teheran

Dr Mohsen Asadi Lari
Head, Department of Epidemiology
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OBSERVERS

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Dr El Tayeb Ahmed El Sayed
Assistant Undersecretary, Public Health and Emergency
Federal Ministry of Health
Khartoum

WHO SECRETARIAT

Dr Hussein A. Gezairy	Regional Director	WHO/EMRO
Dr Abdullah Assa'edi	Deputy Regional Director	WHO/EMRO
Dr Naeema El Gaaseer	Assistant Regional Director	WHO/EMRO
Dr Amit Prasad	Technical Officer, Health Equity Impact Assessment	WHO Centre for Health and Development, Kobe, Japan
Dr Mohammad Assai	Regional Adviser, Community-based Initiatives	WHO/EMRO
Dr Sameen Siddiqi	Coordinator, Health Care Delivery	WHO/EMRO
Dr Abdi Momin	Regional Adviser, Health Policy and Planning	WHO/EMRO
Mr Wael Saber	Technical Assistant, Evidence-based Health Situation and Trend Assessment	WHO/EMRO
Mr Ahmed Bayoumi	Technical Assistant, Evidence-based Health Situation and Trend Assessment	WHO/EMRO
Dr Susan Watts	Technical Assistant, Health Policy and Planning	WHO/EMRO
Dr Faten Ben Abdel Aziz	Regional Adviser, Health Education	WHO/EMRO
Ms Mona Abou Naga	Basic development needs programme coordinator	WHO/Egypt
Ms Samira Jabal	Basic development needs focal point	WHO/Morocco
Dr Rehman Khattak	Community-based initiatives focal point	WHO/Pakistan
Dr Rania Sharaway	Community-based initiatives focal point	WHO/Sudan

Dr Ali Garraoui	National professional officer	WHO/Tunisia
Ms Sarah El Rashidi	Technical officer, Community-based Initiatives	WHO/EMRO
Ms Evelyn Hannalla	Senior secretary, Community-based Initiatives	WHO/EMRO
Ms Dalia Mohamed	Secretary, Community-based Initiatives	WHO/EMRO

Annex 4

Results of Urban HEART workshop evaluation

	Question	No. of participants who responded within each category				
		Excellent	Good	Fair	Poor	DNA*
1.	Instructors' ability to make complex topics easy to understand	6	13	3		
2.	Instructors' ability to answer questions	7	11	4		
3.	Instructor's ability to manage time	3	11	7	1	
4.	Comprehensiveness of the workshop program	8	9	5		
5.	Overall quality of the training	6	10	6		
6.	Your level of understanding of the material	8	12	1		1
7.	Likelihood of using Urban HEART in your country	6	11	3		2
8.	Your level of confidence in applying Urban HEART	5	14	1		2

	Question	Yes	No	DNA*
9.	Did the workshop fulfill your expectations?	17	3	2

	Question	#1	#2
10.	Which sections would you like to see more of?	Matrix and Monitor	Monitoring and evaluation, interventions

	Question	#1	#2
11.	Which sections would you like to see less of?	Country experience	Data quality
12.	General suggestions for improvements in the Urban HEART training workshop	Longer workshop	More participatory format

* DNA = did not answer